IWK Health Centre

DALHOUSIE UNIVERSITY
FACULTY OF MEDICINE
Department of Psychiatry

# DEPARTMENT OF PSYCHIATRY
# CHILD & ADOLESCENT SUBSPECIALTY
# RESIDENCY PROGRAM

## PART I – *RESIDENCY APPLICATION*

| ***Personal Information:*** ***(To be completed by candidate)*** | | | | | |
|---|---|---|---|---|---|
| Applicant Name: | | | | | |
| Present Address: | | | | | |
| | | | | | |
| City: | | Province: | | Postal Code: | |
| Permanent Address: (If different from above) | | | | | |
| | | | | | |
| Social Insurance Number: | | | Telephone: | | |
| Fax: | | Email Address: | | | |
| Current Year of Training: | PGY ___ ☐ N/A | | Proposed Start Date: | July 20___ | |

| ***Academic History – Please include a copy of your Medical School Transcripts.*** | | | |
|---|---|---|---|
| A. DEGREES | | | |
| Degree/Diploma | University/Institution | Dates Attended (MM/YY) | Language of Instruction |
| | | | |
| | | | |
| | | | |
| B. CURRENT APPOINTMENT | | | |
| Dates | Nature of Appointment | Hospital, University, Affiliation, Location | |
| | | | |
| | | | |
| | | | |
| | | | |

| ***Licensure and Employment*** | | | | |
|---|---|---|---|---|
| A. Are you licensed to practice in the Province of Nova Scotia? | | | | ☐ Yes ☐ No ☐ N/A |
| If Yes: | General License | | Expiry Date | |
| | Education License Number | | Expiry Date | |
| If No: | Are you eligible for the Educational License in Nova Scotia | | | ☐ Yes ☐ No ☐ N/A |
| If No: | Are you registered with another Medical Licensing Body? | | | ☐ Yes ☐ No ☐ N/A |
| If YES, Specify | | Registration Number | | |

**NOTE: You must arrange for written confirmation of your status as a member in good standing of your professional body to be sent to the office of Dr. David Lovas. Your application will <u>NOT</u> be processed without it.**

| | |
|---|---|
| B. Have you passed the Medical Council of Canada Evaluating Examination?<br>(This does not apply to graduates of Canadian or U.S. Medical Schools.) | ☐ Yes ☐ No ☐ N/A |
| C. Have you passed the Royal College of Physicians and Surgeons Psychiatry Specialty Examination?<br>(If you are currently enrolled in a general Psychiatry residency program, please check N/A.) | ☐ Yes ☐ No ☐ N/A |
| **If YES, please enclose a clear photocopy of your results.** | |
| D. Are you legally entitled to work in Canada?<br>(Those entitled are Canadian Citizens or Landed Immigrants) | ☐ Yes ☐ No |

## Part II – *ATTACHMENTS*

1. Written Confirmation of your status as a Member in a Good Standing within your professional body to be sent to:

**Dr. David Lovas**
Program Director
Child and Adolescent Psychiatry Subspecialty Residency
IWK Psychiatry
5850/5980 University Ave, PO Box 9700
Halifax, NS B3K 6R8
Tel: 902-470-8375 | Fax: 902-470-7893

2. Copy of your current C.V.
3. Copy of your
   a) Medical Diploma from Medical School
   b) General or Educational License
4. Three letters of reference

Please provide names, titles and full contact information for all referees below.

| |
|---|
| **Referee A:** |
| **Contact information:** |
| |
| **Referee B:** |
| **Contact information:** |
| |
| **Referee C:** |
| **Contact information:** |
| |

## Part III – *DECLARATION*

**Must be completed by ALL applicants**

| | |
|---|---|
| 1. Have you ever been convicted of a criminal offense for which a pardon has not been granted? | ☐ Yes ☐ No |
| 2. Have you ever been convicted of any other offence (for which a pardon has not been granted) that may affect your eligibility for educational licensing in Nova Scotia? | ☐ Yes ☐ No |
| 3. Are there charges pending for an alleged offence that may affect your eligibility for educational licensing in Nova Scotia?<br><br>If YES to any of the above, please provide details below: | ☐ Yes ☐ No |
| | |
| | |
| 4. Have you ever been subject to a disciplinary hearing of a medical licensing authority, or a licensing authority within your discipline?<br><br>If YES, provide details below: | ☐ Yes ☐ No |
| | |
| | |
| 5. Have you ever been denied licensure by a medical licensing authority or had such licensure revoked or limited?<br><br>If YES, provide details below: | ☐ Yes ☐ No |
| | |
| 6. Have you ever been disciplined, suspended or dismissed from an undergraduate or postgraduate educational program?<br><br>If YES, provide details below: | ☐ Yes ☐ No |
| | |
| 7. Do you have a Return of Service Agreement to any health authority (federal or provincial) or other country?<br><br>If YES, provide details below: | ☐ Yes ☐ No |
| | |

**I hereby certify that the information on this form and attachments is true and complete. I understand that I shall be disqualified if information is withheld or false information has been provided and that any appointment already made or begun will be cancelled and all credit revoked.**

| | |
|---|---|
| **Signature of Applicant** | **Date** |

## Part IV - *CHECKLIST*

**NOTE:** *Application will <u>not</u> be processed without all required items on this checklist. Indicate you have completed each section by checking the appropriate "YES" OR "N/A" and initialing where indicated. Please include this checklist with your application.*

**HAVE YOU…**

| | | | |
|---|---|---|---|
| 1. Completed Part I? | ☐ Yes | Your Initials | |
| 2. Completed Part II? | ☐ Yes | Your Initials | |
| 3. Completed Part III? | ☐ Yes | Your Initials | |

**<u>This form must be completed and sent with Parts I, II, & III to:</u>**

**Dr. David Lovas**
Program Director
Child and Adolescent Psychiatry Subspecialty Residency
IWK Psychiatry
5850/5980 University Ave, PO Box 9700
Halifax, NS B3K 6R8
Tel: 902-470-8375 | Fax: 902-470-7893

E-mail: David.Lovas@iwk.nshealth.ca